MAP-529
(Revised 1/09)

Kentucky Medicaid
Change Information Form

Kentucky Medicaid Provider Number

[_][_][_][_][_][_][_][_][_]

NPI (National Provider Identifier)

[_][_][_][_][_][_][_][_][_][_]

Provider Name: _____

Email Address: _____

PHYSICAL ADDRESS

STREET_____

CITY_____

STATE_____ZIP CODE_____-_____

TELEPHONE: _____

FAX NUMBER: _____

PAY-TO-ADDRESS

STREET_____

CITY_____

STATE_____ ZIP CODE_____-_____

TELEPHONE: _____

FAX NUMBER: _____

CORRESPONDENCE ADDRESS

STREET_____

CITY_____

STATE_____ ZIP CODE_____-_____

TELEPHONE: _____

FAX NUMBER: _____

1099 ADDRESS

NAME _____

STREET _____

CITY_____

STATE _____ ZIP CODE_____-_____

TELEPHONE: _____

FAX NUMBER: _____

By signing below, I authorize Kentucky Medicaid to change the current information on file to the information indicated on this form.

Provider Signature: _____ Date: _____
(If this form is being completed for an individual provider, the individual provider must sign.)

Printed Name of Person Signing this Form: _____

RETURN TO:
Kentucky Medicaid
P.O. 2110
Frankfort, KY 40602-2100
Telephone: (877) 838-5085